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PROCEEDINGS OF THE 1960 ANNUAL CONFERENCE OF THE SURGEON GENERAL, PUBLIC HEALTH SERVICE AND CHIEF, CHILDREN'S BUREAU WITH STATE AND TERRITORIAL HEALTH OFFICERS HELD IN SAN FRANCISCO, CALIFORNIA ON OCTOBER 26-28, 1960

Public Health Service
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1961

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Proceedings

1960 Annual Conference

of the SURGEON GENERAL, PUBLIC HEALTH SERVICE

and CHIEF, CHILDREN'S BUREAU

with STATE AND TERRITORIAL HEALTH OFFICERS

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U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

62

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of the

SURGEON GENERAL, PUBLIC HEALTH SERVICE

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October 26-28
San Francisco, Calif.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

I

1959-1960

OFFICERS

of the

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

President:
Wilson T. Sowder, M.D., State Health Officer
Florida State Board of Health, Jacksonville

Vice President:
Mack I. Shanholtz, M.D., State Health Commissioner
Virginia State Department of Health, Richmond

Secretary-Treasurer:
Andrew C. Offutt, M.D., State Health Commissioner
and Secretary, Indiana State Board of Health, Indianapolis

Executive Committee:
Robert B. Aiken, M.D., State Health Commissioner
Vermont Department of Health, Burlington

Ralph E. Dwork, M.D., Director of Health
Ohio Department of Health, Columbus

Charles L. Wilbar, Jr., M.D., Secretary of Health
Pennsylvania Department of Health, Harrisburg

D. G. Gill, M.D., State Health Officer
Alabama State Department of Public Health, Montgomery

Public Health Service Publication No. 830

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California State Department of Public Health, Berkeley

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Ralph E. Dwork, M.D., Director of Health
Ohio Department of Health, Columbus

Wilson T. Sowder, M.D., State Health Officer
Florida State Board of Health, Jacksonville

Floyd I. Hudson, M.D., Executive Secretary
Delaware State Board of Health, Dover

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Combined Conferences
of the Surgeon General, Public Health Service, and the Chief,
Children's Bureau, with the State and Territorial Health Officers

General Session **Wednesday, October 26, 1960**

Presiding: Dr. Leroy E. Burney, Surgeon General

SUMMARY OF OPENING REMARKS BY DR. BURNEY

I join with your Association president, Dr. Wilson Sowder of Florida, in welcoming all of you to the golden State of California. Let me also express our thanks to Dr. Malcolm Merrill and the California State Department of Public Health -- our excellent hosts for this meeting in San Francisco.

During the roll call of your names by States, I once more felt how good it is to see the familiar faces and equally good to greet the new health officers. At this session, I believe a special greeting is appropriate for our fiftieth and newest State, Hawaii, and its health director Dr. Richard Lee--and old friend with new and well deserved status. (Applause)

I have been attending these meetings for a long while, beginning with my first assignment in Washington around 1935. Throughout these years, I have been repeatedly impressed with the splendid example exemplified in these conferences of how a Federal agency and State authorities can work together progressively and can develop effective working relationships as well as close friendships. I hope this will continue in the years to come, regardless of changes in membership and administration.

I also want to mention, with much appreciation, the extra opportunities we had during the past year to work with State health officers. Three of them were on the delegation for the World Health Assembly: Dr. Lee, well known and long respected throughout the Western Pacific and elsewhere for his international health activities; Dr. Wilson Sowder, who made a distinct contribution not only as a linguist but also in the way he circulated among and talked with delegation members from many countries; and Dr. Guillermo Arbona from Puerto Rico in his third successive year as an excellent member.

Additionally, many health officers from both the State and local levels have given service on various committees and councils connected

with the Public Health Service. For example, Dr. Merrill is a member of our National Advisory Health Council and was one of three subcommittee members who prepared the environmental health report, which I consider a milestone. Then we again had the services of Dr. Sowder on a new medical care committee; of Dr. Hutcheson and Dr. Barr on our poliomyelitis control committee; and Dr. Hilleboe on our National Advisory Committee on Radiation.

I haven't either the time or the memory to mention all those who have been similarly helpful. Nevertheless, any review of our good relationships has particular point when we consider that nearly fifty years have passed since the Surgeon General and the State and Territorial health officers last met in San Francisco in annual conference. That was in 1911, the first time they met outside of Washington. We don't know why the conference was held here then; but we do know that Surgeon General Walter Wyman was detained in Washington on "official matters of great urgency." The date was June 24, 1911, so perhaps the detainer was last-minute budget and appropriation business in the Congress. Assistant Surgeon General John W. Kerr, chief of the Division of Scientific Research from 1905 to 1918, substituted for Dr. Wyman.

Only four other annual conferences of the Surgeon General with State health officers were held outside of Washington: 1913 in Minneapolis, Boston in 1921, Chicago in 1924, and St. Paul in 1928, when the forty-third annual Conference of State and Provincial Health Authorities of North America was held conjunctively with ours. Thereafter, the two groups met in Washington at the same time. The Conference of State and Provincial Health Authorities continues to function actively, but for some years its annual meetings usually have been held in conjunction with those of the American or Canadian Public Health Association.

In the old days, the APHA annual meetings were widely separate from our annual conferences, in terms of location as well as dates. This was especially true in 1911, when the APHA met in Havana, Cuba.

The health officers conferring in San Francisco in 1911 were concerned with the reporting of infectious diseases, anti-plague measures, methods for the epidemiologic investigation of poliomyelitis, railway sanitation, and transportation of the dead. They were interested in what Dr. Kerr had to say about protecting Alaska from smallpox, and the entire country from the introduction of cholera. But perhaps the most interesting items were the reports of the Hygienic Laboratory's research on measles and poliomyelitis. Young Dr. Wade Hampton Frost was engaged in his first epidemiologic investigation of polio that year. And the Public Health Service was cooperating with some of the Great Lakes States in an exploratory survey of sanitary conditions in relation to typhoid fever.

Two years later, when the conference met in Minneapolis, the Public Health Service's Ohio River survey was being launched, an interdisciplinary scientific study designed by the great Professor Earle B. Phelps

of the Hygienic Laboratory. He was one of this country's first pioneers in environmental research.

The concerns of health officers and the research interests of the Public Health Service in 1911 may seem remote from the realities of public health in 1960. But I observe in our current agenda prepared by committees of the Association of State and Territorial Health Officers that poliomyelitis, measles, and environmental problems--1960 style in each instance--are subject of as lively interest today as they were fifty years ago. The notable differences are, of course, the new guises in which old problems appear, and the growth in the range of our mutual concerns.

Here are some of the areas which now concern us and in which we should move ahead.

I. Water Pollution Control

A. Great Lakes and Illinois Waterway Study

It is no coincidence that the Public Health Service is still concerned with water pollution in the Great Lakes area. This is the northern gateway to the Nation's great heartland; and the locus of a tremendous and rapidly developing industrial-metropolitan complex. It encompasses vast water resources, and is the source of far-reaching pollution.

For fiscal year 1961, the Congress has appropriated $500,000 to the Public Health Service for the first phase of a comprehensive study leading to the development of a plan for controlling and preventing pollution in and around the United States' portion of the Great Lakes and the Illinois waterway. The study is expected to cost $12 million and to take six years to complete.

The first phase will be directed to obtaining information for the Special Master appointed by the United States Supreme Court to consider the case of Wisconsin et al. versus Illinois, and Illinois versus the Lake States. The decision to be made by the Special Master will concern the diversion of water from Lake Michigan into the Illinois River.

B. National Conference on Water Pollution

At the request of the President, the HEW Secretary has asked the Public Health Service to arrange a National Conference on Water Pollution to "provide a forum in which all concerned can confront and better appreciate their mutual responsibility for solving this pressing problem." The conference will be held in December 1960, in Washington, D. C., and we expect about 1,200 delegates and observers. A 35-member steering committee, representing major groups concerned with water pollution, has advised us on developing the conference. Dr. Russell Teague represents the Association of

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State and Territorial Health Officers.

Panel sessions will be devoted to (1) the impact of water pollution on public health, welfare, and the national economy; (2) its relation to water resources management; (3) legal, financial, and public awareness aspects and the roles of government and industry; and (4) needs for research.

II. Radiological Health

We have been pleased with the States' activities in the preparatory work on the radiation intelligence network, and we want your further cooperation in its expansion and inauguration in 1962. The goal is to obtain more comprehensive data on radiation-exposure sources and levels, and on radiation dosage levels and total population dose. Previous data collection programs are being expanded, such as the milk sampling network. As you know, we now have regional laboratory facilities at Las Vegas, Nevada; Montgomery, Alabama; and Rockville, Maryland.

Appropriations for 1961 have been increased to nearly $7 million, as compared with $2.5 million for 1960. From this increase, $500,000 will inaugurate the first Public Health Service training grant program in radiological health. Grants will go for the training of 75 to 100 radiation health specialists in the 10 universities now offering curricula in this specialized field.

III. Environmental Health

Certainly environmental health and long-term illness are among the major areas in which we need to move ahead in the next decade through an expanded nationwide effort, comparable with the expansion in medical research and hospital construction in the 1950's.

First, we need expansion in research and training in the environmental sciences. The Public Health Service has made some contributions here and is now preparing for broader planning and coordination of fundamental and applied research. This Congress has approved an allocation of $785,000 toward planning an appropriate environmental health research center. This will be a large institution with several laboratories working on such phases as radiation, occupational health, toxicology, physiology, and other related fields.

Now I've asked several of our program officers to brief you on certain topics and events in which you are interested. Dr. C. A. Smith, in charge of our Communicable Disease Center, will brief you on the poliomyelitis picture.

SUMMARIES OF OTHER DISCUSSANTS

IV. Poliomyelitis Control

DR. SMITH: First, I want to express general thanks for your co-operation and interest in our surveillance procedures. Reports have been coming in regularly and are well documented. The year 1960 has shown an over-all decrease in number of cases. As of October 15, 1960, there were 2,553 polio cases reported, of which 1,738 were paralytic. Epidemics have not been particularly impressive. The largest epidemic was in Puerto Rico; others have been scattered throughout the country, reported most often as Type 1 and several as Type 3.

The potency of Salk vaccine is steadily increasing, and I have been told that the Division of Biologic Standards is about to raise its potency requirements. Also purified vaccine is now in the stage of becoming a usable tool, and the quadruple vaccines are coming into greater use each year. The amount of quadruple vaccine sold has been enough to take care of at least half the children born this year.

As to the effectiveness of Salk vaccine, our best figures last year showed a rate of about 90-percent effectiveness. This rate dropped to about 80 percent when we re-examined Des Moines; but the first figures on Providence showed about 95 percent. Thus, we are willing to stay with our first rough estimate of about 85 to 90 percent as the effectiveness rate for Salk vaccine. This rate may very well increase as the vaccine potency is increased. Unfortunately, the use of the vaccine is still falling off. The amount sold last year was greater than replacement requirements, but showed little progress toward complete immunization across the country.

The Ad Hoc Committee on Live Poliovirus Vaccine, established by Dr. Burney in 1958 and chaired by Dr. Roderick Murray, has been working on the safety factor. Reversion to virulence is still a question in some people's minds. I won't discuss here the extensive field trials that have been carried on, except to say that in the three field trials in Miami, Berlin, and Minnesota using the Cox-Lederle strain, a few cases occurring within three weeks after the trials left some shadow of a doubt on the use of this strain.

Last August 24, the Surgeon General announced that the oral strains were suitable for licensing in this country; and on August 26 recommendations were made to the manufacturers for the production of the oral vaccine. The biological laboratories may now apply for licenses. Licensing conditions and production problems will be such that undoubtedly we may not look forward to having live virus vaccine in great quantity for next year's polio season.

In September 1960 the Surgeon General appointed another large committee to consider the whole problem of polio control. It includes not only professional competence in all the areas but also consumer

groups. At the Communicable Disease Center in October a planning group met on the agenda. The group was primarily professional, and discussed all the technical problems involved in the production and use of live vaccine as well as the necessity for continuing use of Salk vaccine at this time, before the next polio season. Also discussed were dosage schedules, the place of Salk vaccine now and in the future, the use of live vaccine in mass campaigns and for early elimination of epidemic situations, and the general community organization for the elimination of paralytic polio.

Early in January 1961 the full committee will meet at CDC to make final resolutions based on the agenda discussions and within the present state of technical knowledge. We hope some strong recommendations will be made for continuing Salk vaccine for the coming polio season, and some general ideas developed on the use of oral vaccine in the future.

DR. BURNEY: I would like Dr. William Stewart, chief of our Division of Public Health Methods, to brief you on what we are doing in the field of medical care, organization, patterns of administration, and the like.

V. Medical Care

DR. STEWART: In medical care administration, there are four events of the past year to report. They involve the Public Health Service and also reflect, I believe, our present status of activities.

First, on the reorganization of the Public Health Service, I want to quote directly from the Final Report of the Study Group on Mission and Organization of the Public Health Service:

> "The next great nationwide health efforts may be expected in two broad areas: the physical environment and comprehensive health care ... The former will involve the development and application of new, more efficient techniques to measure, evaluate, and control natural and artificial factors in the environment which affect health and safety. The latter will involve the development of adequate supplies of well qualified personnel, appropriate facilities, new and more efficient methods to render comprehensive services to the American people....
>
> "During the past decade, a concept of comprehensive health care has come into clearer focus. It comprises a continuum of preventive, curative, and restorative services to individuals and families in which personnel with varied technical skills participate, under both private and public auspices.
>
> "In the same decade, there has been a growing concern for the provision and financing of these services to all segments of the population. Adequate supplies of well qualified health personnel, appropriate hospital and medical facilities, and more efficient

methods of rendering comprehensive health care are viewed as the major national needs in this broad area."

Thus, you can see that the reorganization is based, in part, upon the concept that medical care administration is designated for primary consideration and effort.

The second event to report concerns an appropriation increase of $100,000 that originated in the Senate appropriations committee for the purpose described in that committee's report as follows:

"The increase recommended will permit further strengthening of the staff of the Division of Public Health Methods to increase its capacity for carrying out studies of the needs for and the problems of organizing and providing medical care services for the Nation. The committee notes with interest the data on the nature of illness and disability in the general population resulting from the operation of the National Health Survey. These data have presented an altogether new picture of the changing distribution and character of disability and illness on a current basis amongst the people of the Nation and their utilization of health services. Determining the significance of these changes and their relation to needs for and the organization of medical care services, health personnel, and the problem of financing health services is an important additional area of study if local and national health action is to be realistic and meaningful."

My third report concerns the participation of some of us in the Service on the HEW Secretary's task force on health insurance for the aged, in the spring of 1960. During this activity it became apparent to us that any scheme of financing health care for a large segment of the population, whether it is a governmental or nongovernmental program, will call for decisions that will fix certain patterns of medical care, create new organizational patterns, and generally affect the level of health of the area involved. It was also seen that the Public Health Service must participate more actively in the medical care administration field, since the promotion and protection of health is our business.

The fourth and last event to be reported concerns the National Advisory Health Council. As you know, one of its functions is to advise the Surgeon General on over-all policy issues. At the Council's June 1960 meeting, members spent a full day on medical care administration; and then appointed a subcommittee augmented by medical care experts to explore the subject in depth. The Surgeon General asked this subcommittee, chaired by Dr. Lowell T. Coggeshall, to consider and report on (a) how personal health services in the broader sense may best be developed in the United States and (b) what the role of the Public Health Service should be. Staff papers are currently being prepared on personnel, facilities, methods and sources of financing, quality of medical care, and organization.

DR. BURNEY: Now we might say a word about the $2 million increase in the general health grant appropriation for fiscal 1961, aimed toward upgrading the quality of care in nursing homes. Our regional medical directors have been working with you and your staffs for about five months on the development of State plans. We hope these plans will assure the Congress that the additional funds made available will have a direct, beneficial impact on services at the local level. There is an obligation upon all of us to see that these funds are used for the intended purpose; that is, to improve and increase local nursing home programs.

We must show good faith with the Congress and its interest in nursing home care. The Public Health Service will have to justify the increase for nursing home programs before the next Congress if health agencies are to anticipate sustained effort in this area. Nursing home care will acquire greater importance with each passing year.

VI. Research Proposals

The proposals of the ASTHO Research Committee are always interesting to us. The 1960 agenda reflects the growing interest of health departments in scientific and operational research, and rightfully so. One recommendation is particularly significant: that is, the request that the Public Health Service and the Children's Bureau increase assistance to States for research on application of scientific findings. This calls for:

1. Experimentation in the application of new scientific findings and the development of more effective public health procedures therein.

2. Experimentation in new administrative approaches to community health services, based on changing social, medical, and technologic problems.

3. Studies on the organization of health and related services.

4. Demonstrations.

This field is so important that it might well call for a study group oriented to application of scientific knowledge, just as we have other study groups concerned with specific research in—for example—environmental health.

I can assure you that the Service always welcomes the ASTHO Research Committee's opinion on how we can help State and local health departments in their design and conduct of high quality research projects. Community health research requires many specialists and well qualified research personnel. The importance of the team approach is surely obvious. The chief investigator must be competent to design a scientifically sound study and must do so before he assembles his team. Otherwise funds and personnel may be wasted, and what is even more damaging, the study results may be meager or without scientific value.

Let me report briefly on research in State and local health departments and the funds for this made available by Congress. Over the past ten years, there has been a ten-fold increase in annual funds awarded to official health agencies for research purposes: from about $287,000 in 1951 to $2.75 million in 1960. Grants have increased from 19 in 1951 to 101 in 1960; and 28 States and 15 local health departments participated in 1960. New projects increased from 10 in 1951 to 44 in 1959. Ten State health departments now have some central machinery for planning, developing, and coordinating research: 4 years ago, none had taken this step. Florida was the first, and at this time these States also have a unit, committee, or designated officer with research responsibility: California, Georgia, Kentucky, Maryland, New York, Pennsylvania, Rhode Island, Utah, and Washington.

VII. Metropolitan Health Planning

I haven't enough time left to discuss with you all my notes on metropolitan health planning but perhaps they can be included in the published proceedings for later reading.1/

1/ Additional notes on metropolitan health planning:

The need is urgent for State assistance in solving the contemporary problems of urban life in a rapidly changing physical and social environment. Health is by no means the only problem to be faced here, but it is a vast one that includes these major factors:

1. Environmental factors: water, air, food, waste disposal of all types, shelter, and work hazards.

2. Hospitals and other health facilities.

3. Health services, including medical services.

Furthermore, health is a component of other metropolitan problems in education, transportation, traffic control, fire protection, land use, housing, juvenile delinquency, adult crime, and the like.

Ninety years ago, when States began to establish their health organizations, our cities were in much the same situation as they are today in having to deal with rapid population increase, industrial expansion, slums in central city sections, and problems in fringe areas. They also had to cope with explosive and uncontrollable epidemics. Ninety years ago States did little or nothing to help their cities. Today they cannot afford to repeat that old pattern.

In many instances, the structure of local government is such that State action is the only resource for help. We hope that State health departments will recognize the problems and use their influence at the top levels of their State governments. They can also equip themselves to participate in metropolitan health planning, if only by designating one staff member to cooperate with State and local authorities in planning agencies, public works and public welfare agencies, and with other groups and persons concerned.

I want to say this, however. There are increasing demands for Federal cooperation with cities and metropolitan areas. These voices and areas are growing in volume and the pressures on us are great. It is my philosophy that States are sovereign in matters of public health and that it is the function of the Public Health Service to work with and through official State agencies. We do have one law that instructs us to work directly with a local area on air pollution problems. But when we have such requests from local areas we notify the State health department, and request its assistance in the local problem. I believe our effective relationships have been and will be maintained because the Public Health Service honors the sovereignty of States. But problems and pressures in metropolitan health planning are becoming increasingly persistent and important, and we need your understanding. We ask your help and tolerance in our efforts to meet the needs of metropolitan areas through established channels for technical assistance to States and their political subdivisions.

VIII. Reorganization of the Public Health Service

I know you have been keenly interested in our plans for reorganization of the Public Health Service. First I want to pay special tribute to Dr. James Hundley and his study group for an outstanding job. Members of the group were selected because they are known to be creative, and not afraid to express new ideas. Those of you who have read their published report on the mission and organization of the Service will surely agree that they deserve commendation for the high-level thinking and decision they gave to an extremely difficult task. Rufus Miles, the able administrator on the Secretary's staff, said this to me:

> "We tend to be conscious of the usual limits of self-analysis. It takes unusual people to rise above these limitations. This group proved itself to have been constituted of unusual people. It showed a degree of both imagination and objectivity which exceeded that of any self-study I have ever seen. The product has provided the basis for decisions and action which should be of great value to the Public Health Service, the Department, and the Nation over the next decade."

The study group might not have agreed at the outset that it is easier to plan than to put a plan into effect. But I have kept many of them at work on special problems involved in implementation. So they are proving their own conclusion that organization is not a one-time job. It is a continuing process in efficient administration.

Last winter, when the group had been at work for about three weeks, the 1960 Institute on Government was held at San Diego. One of the most provocative papers presented there was called "Planned Obsolescence in Government." The author, Louis J. Kroeger, executive vice-president of Griffenhagen-Kroeger, Inc., gave public officials food for much serious thought. He noted that "efforts at reorganization, at all levels of government, usually come to a peak at intervals of from 7 to 10 years. Seldom have these efforts had much of the characteristic of planned obsolescence.

Only occasionally have they succeeded in abolishing functions or reorganizations which had long grown obsolete, not by planning, but by circumstance; and more often they simply provided for the regrouping of agencies and functions to fit the passing fashion in organization."

It is virtually impossible for a governmental administrator to abolish a function or an organization established by law. But I believe that our plans for reorganization of the Public Health Service involve more than a regrouping of our existing functions and established organizational units. Underlying our plans is a firm conviction that a health agency, more than many other governmental agencies, must be peculiarly alert -- not only to the scientific and technical changes affecting its basic functions, but also to changes in the social and economic goals of the people for whom the agency was created and is maintained. Such an agency needs to plan corresponding shifts in its functions, including the elimination of some. Only by so doing can it be prepared to give better services of the kinds the people desire.

I have asked Dr. Arnold Kurlander to give you a brief review of reorganization plans and what has been done to the present time. To do the full job, we shall need some legislation which we are confident will be enacted in the interest of better government, whatever the outcome of the 1960 election may be.

DR. KURLANDER: Why are we going through this reorganization? Briefly, so we can do a better job for the people, for health agencies, universities, and other institutions; and a better job for ourselves by providing a flexible organizational structure whereby the Public Health Service will better be able to accept new responsibilities that are ahead, though not yet fully identified.

Legislation to create the new bureau structure was introduced in the last Congress, but no action was taken then because other matters of high priority were given first consideration. We are hopeful for favorable consideration in the coming session of Congress.

Basically, the new plan calls for four operating bureaus and two independent units, as follows:

a. Bureau of Environmental Health
b. Bureau of Community Health
c. Bureau of Medical Services
d. National Institutes of Health
e. National Library of Medicine
f. National Center for Health Statistics.

We are now forming the new divisions and other units that ultimately will be placed under the new bureaus, and we hope that most of the difficult details will be accomplished by the time that Congress acts upon our legislation.

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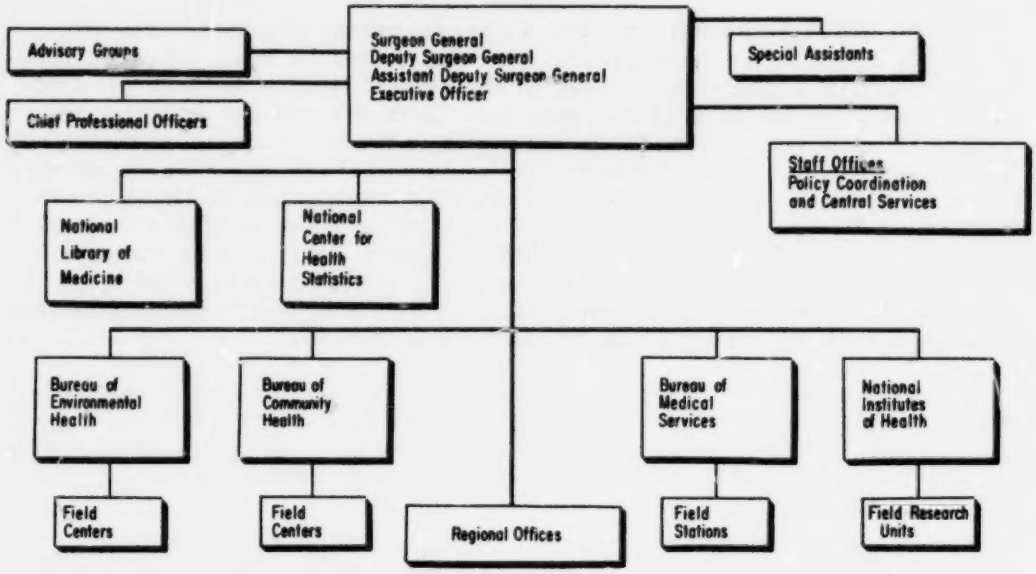
CHART 5

NEW ORGANIZATION OF THE PUBLIC HEALTH SERVICE 1960



Those of you who have the publication Final Report of the Study Group on Mission and Organization of the Public Health Service have seen the charts and read the discussion on planning the various organizational units. For example, the proposed Bureau of Environmental Health will include the already existing Division of Water Supply and Pollution Control and the Division of Radiological Health. The Division of Air Pollution has been formed by combining two programs: the medical component of air pollution previously in the Division of Special Health Services; and the engineering component previously in the Division of Engineering Services. Mr. Vernon G. MacKenzie has been appointed chief.

The Division of Occupational Health is established with Dr. Harold Magnuson as chief. With many new enterprises developing in this field, division status has been accorded to what was formerly the occupational health branch in the Division of Special Health Services.

The next step will be the grouping of general environmental health services into a Division of Milk, Food, Interstate and Community Sanitation. It will be headed by Mr. Wesley Gilbertson, who has been chief of the Division of Engineering Services. The latter division will be abolished when the new one is formally established.

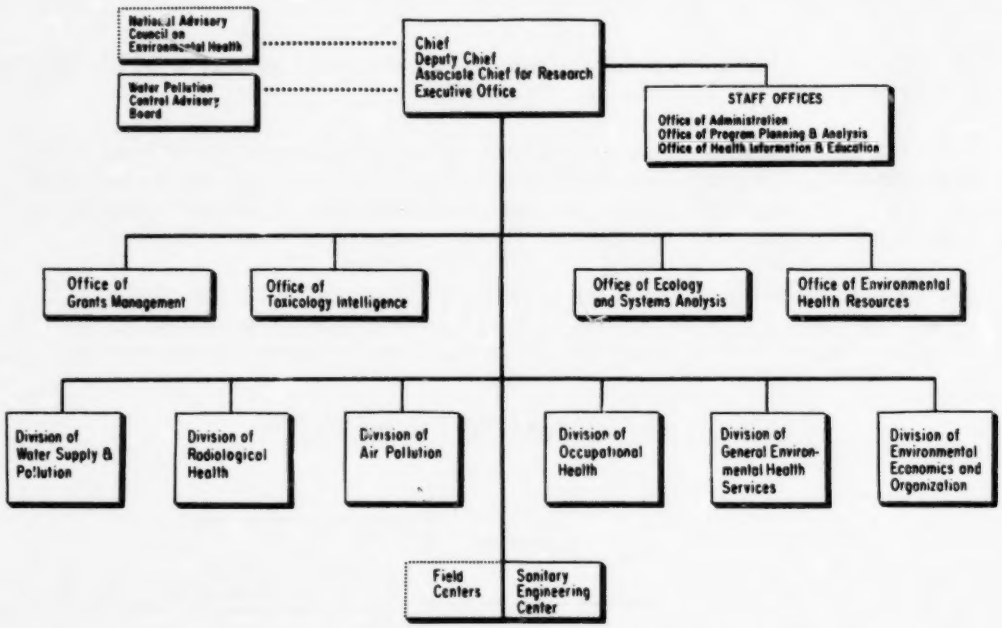
We are just beginning to study the functions and structure of the proposed Division of Environmental Economics and Organization. No concrete action has been taken yet.

The mission and organization report showed other proposed staff and special offices under the proposed Bureau of Environmental Health, such as the Office of Grants Management, Office of Toxicology Intelligence, Office of Ecology and Systems Analysis, and Office of Environmental Health Resources. Action on these is postponed until the operating divisions are fully organized.

Establishing new organizational units is not as simple as my brief recount may sound. Each new unit requires careful study of function, structure, responsibility, interrelationships both inside and outside the Public Health Service, as well as fiscal and administrative problems and the very human considerations about personnel.

CHART 6

BUREAU OF ENVIRONMENTAL HEALTH


National Advisory Council on Environmental Health
Water Pollution Control Advisory Board
Chief
Deputy Chief
Associate Chief for Research
Executive Office
STAFF OFFICES
Office of Administration
Office of Program Planning & Analysis
Office of Health Information & Education
Office of Grants Management
Office of Toxicology Intelligence
Office of Ecology and Systems Analysis
Office of Environmental Health Resources
Division of Water Supply & Pollution
Division of Radiological Health
Division of Air Pollution
Division of Occupational Health
Division of General Environmental Health Services
Division of Environmental Economics and Organization
Field Centers
Sanitary Engineering Center

Under the proposed Bureau of Community Health will be the new Division of Community Health Practice. It will be headed by Dr. James K. Shafer. You may recall that the report recommended that this division have the unique responsibility for studies and action programs designed to unify and integrate general health services delivered through public and private channels; for expansion of studies on medical care organization and financing, together with existing programs in public health practice, research, organization, and financing. The programming of general health grants, public health manpower activities, school health and migrant labor will also be in this division, along with health problems of metropolitan areas. These are complex tasks, in which you are deeply interested. We will keep you informed as the programs are developed.

Several other divisions in this proposed bureau have been established or are in the process. The title of one will probably be the Division of Heart, Cancer, and Chronic Diseases, under Dr. Leslie Knott. The Division of Communicable Diseases will be essentially the Communicable Disease Center as you know it now. The Division of Accident Prevention will be headed by Dr. A. L. Chapman. The Division of Dental Public Health and Resources is now formally established under Dr. Donald Galagan. This is an instance where two divisions (Dental Resources in BMS and Dental Public Health in BSS) were combined into one.

The new Division of Nursing under the direction of Miss Margaret Arnstein also has been formed through a similar combining process.

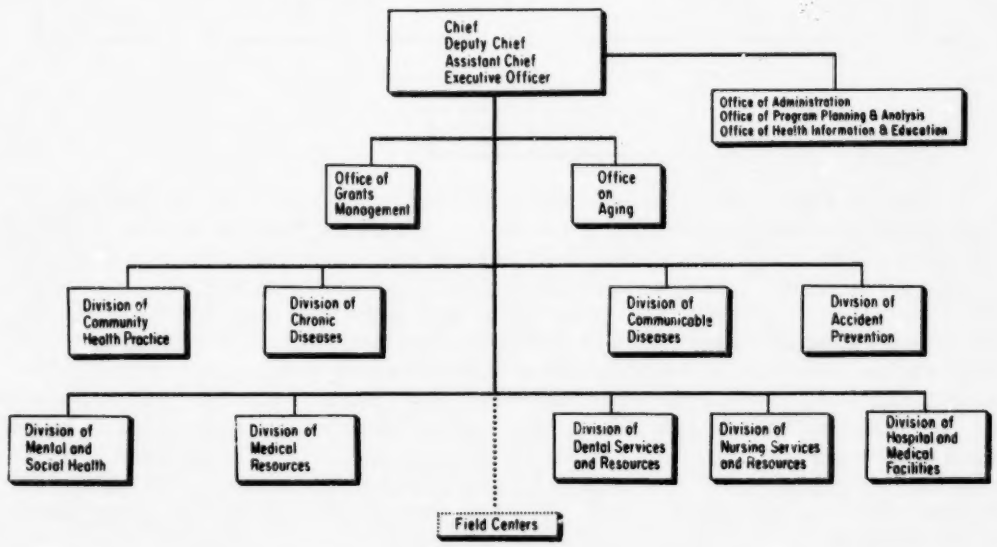
The Division of Hospital and Medical Facilities will soon be transferred from the Bureau of Medical Services to the Bureau of State Services.

Temporarily in abeyance are the two proposed divisions of (1) Medical Resources and (2) Mental and Social Health.

As you undoubtedly know, the study group originally proposed that the responsibility for community mental health services and some other functions be transferred from the National Institute of Mental Health to the proposed Bureau of Community Health, where it would form the nucleus for the last-mentioned proposed division. This recommendation generated enough difference of opinion that the Surgeon General decided to postpone the decision. On the other hand, everyone agreed that the Bureau of Community Health programs should have a strong

CHART 7

BUREAU OF COMMUNITY HEALTH


Chief
Deputy Chief
Assistant Chief
Executive Officer
Office of Administration
Office of Program Planning & Analysis
Office of Health Information & Education
Office of Grants Management
Office on Aging
Division of Community Health Practice
Division of Chronic Diseases
Division of Communicable Diseases
Division of Accident Prevention
Division of Mental and Social Health
Division of Medical Resources
Division of Dental Services and Resources
Division of Nursing Services and Resources
Division of Hospital and Medical Facilities
Field Centers

component of social and behavioral sciences and other disciplines associated with mental health. The question was also raised on whether the Service as a whole is doing all it should be doing in mental health.

Consequently, the Surgeon General is planning a special joint committee to help us review community mental health functions and needs; and advise on integration with general health programs, on manpower and budget questions, and how the Public Health Service might best carry out its role. We have asked for three representatives each from the ASTHO, from the State mental health authorities, and from the National Advisory Mental Health Council to serve on this committee.

We have also assigned a highly qualified mental health consultant, Dr. Mabel Ross, formerly in our New York Regional Office, to the Bureau of State Services. She will assist in the development of (1) mental health components in Bureau programs and (2) effective relationships and liaison activities.

At the National Institutes of Health, three have completed their reorganization (mainly internal), and other institutes are in the process.

In the Office of the Surgeon General the National Center for Health Statistics has been created. Dr. Forrest E. Linder is its chief.

Discussion on reorganization matters is now being carried out with our regional office staffs. We are working out the administrative relationships and the modus operandi between the regional offices and the proposed bureaus. Problems that have been brought up so far seem to be internal rather than related to our basic pattern of working with State health agencies. Nevertheless, we can see opportunities to improve our regional services and assistance to States.

Over the next decade, the Public Health Service will probably need several additional field centers, staffed by highly qualified and technical personnel, to serve a variety of purposes and programs. Certain kinds of research, demonstrations, and other practical studies ought to be carried out where the problems exist -- and this is pointed up by some of your research proposals. Several State health officers have expressed concern that such field centers and staffs might usurp technical and service functions normally carried out by State agencies. This is not our intent and we will take every step to guard against it.

It is important to keep in mind that our organization planning is designed not merely to meet our current responsibilities more efficiently, but also to meet those we anticipate in the next decade. However, the role of the Public Health Service is not clearly foreseen in every area; for example, in developing medical school facilities and medical manpower, medical care for the aging, and water pollution control. At the minimum, we feel an obligation to become better prepared and we have adopted the cardinal principle that our organization must be flexible. We must be able to keep in step with changing needs and emphases, and with new knowledge and situations. The pending legislation

would give us that flexibility, and would enable us to overcome some of the difficulties imposed by the rigid four-bureau structure of the past seventeen years.

DR. BURNEY: Thank you, Dr. Kurlander. Perhaps I should apologize for our long exposition about the Public Health Service. But many things have been happening this year, and these topics seemed worth reporting to you.

Dr. Sowder and several others suggested that it would be helpful to have someone from the Social Security Administration discuss the new program of medical assistance for the aged. I am happy to present Mr. Joseph H. Meyers, Deputy Commissioner of the Social Security Administration, who has come from Washington in answer to your request.

IX. Medical Assistance for the Aged

MR. MEYERS: I appreciate the invitation to be here with you and the opportunity for a discussion about the program. As you know, we had several significant amendments in 1960 to the Social Security Act, but the center of attention was the one which concerned the medical care provisions for the aged. Discussions have moved backward and forward briskly between those who favor the tie-in with the Social Security wage-related programs and those who favor the Federal-State grants-in-aid approach. The 1960 provision authorizes grants to the States for financial assistance to persons aged 65 and over, who are not recipients of public assistance but who cannot meet the costs of "necessary medical services," particularly when significant expenditures are involved.

You here are well aware that persons aged 65 and over have greater medical needs; that their income is also generally lower than that of other adult population groups, is usually a fixed income, and is often a declining one. I believe everyone recognizes the problem, but not everyone recognizes that in addition to the newly authorized program of Medical Assistance for the Aged, the 1960 amendments made a significant increase in the Federal contribution to State expenditures for their regular old-age assistance programs.

Under Title I of the Social Security Act, the existing public assistance program permitted States to make vendor payments--which simply means direct payments to suppliers of medical services. These vendor payments have been made, however, within an over-all average maximum of $65 under the Social Security Act. Many States have moved beyond this. Other States have not, because they felt they needed to concentrate their income maintenance--their cash assistance part of the program--within the $65 limit.

Under the 1960 amendment to the old-age assistance part of the program, a State with an old-age assistance program can receive an increase up to an average of an additional $12 per month per individual for vendor payments for medical care. This means that States now can

get Federal participation in average payments combining cash and medical care up to $77 per month per individual.

Another aspect of the program—and I believe this is a challenge to all of us who work with the MAA (Medical Assistance for the Aged) program—is the combining of the two categories under Title I: old-age assistance (OAA) and MAA. I see two advantages here. First, it is easier for States to build on existing State legislation. Since all have public assistance programs and all have medical assistance activities of one kind or another, States are less likely to need new legislation if they can tie in both programs under Title I.

The other advantage lies in the open-end appropriation available in public assistance—something unique in the grants-in-aid field. The new MAA program would also be open-end; that is, for every dollar that States spend within the confines of the program, Federal money would be available in the percentage that a particular State gets, without limit on the total amount. In other words, there would be no block grant, no allotment, which would make this a liberal program in terms of the leeway given States to include the class of individuals they want to include.

Certainly the program is meant for people who have insufficient income and resources to meet their medical needs and the law requires the setting of reasonable outer limits, but a different and more liberal needs test can now be used than has been used in the OAA assistance program.

The effective date of the MAA amendment was October 1, 1960. There are details and questions still to be resolved, of course, particularly on legal implementation in the States. I understand that four States were expecting to submit their plans sometime during this month, and that seven or eight other States are now working on their plans and hope to begin moving in the early part of next year (1961) when their legislatures meet.

I will end this brief discussion by saying that I have worked closely with our people on the MAA program, and will be glad to add whatever information I can if you have questions. I don't know all the answers but perhaps I can be helpful on points you want to bring up now or later.

Summary of Points Discussed from the Floor

A brief review of the general provisions of PL 86-778 for medical aid for the aged brings out these points:

a. The law amends Title I of the Social Security Act to couple old-age assistance with medical assistance for the aged. It authorizes grants to the States for financial assistance to persons aged 65 years

or over who are not recipients of public assistance but who cannot meet the costs of necessary medical services; and also increases the Federal share in State-local provision of medical services for the aged who do receive old-age assistance.

b. States may elect to furnish medical aid only to people who receive old-age assistance, or only to aged persons who are medically indigent, or to both groups.

c. For MAA approved State plans may not require an eligible age of more than 65 years, nor impose durational residence requirements; they must include "reasonable" standards for determining eligibility for and extent of medical aid.

d. The MAA program provides for payments only to vendors of services rendered to eligible persons.

e. Provisions are made to protect the property of a person receiving MAA during his lifetime and that of his surviving spouse.

f. State plans for MAA must provide payments for some institutional and some non-institutional services. This is to provide for a more balanced program and to prevent States from developing totally inadequate programs, as has been the case in some medical care programs within public assistance categories. The list of services that may be covered could provide comprehensive care, including dental care and dentures. An approved State plan could pay for only inpatient hospital care and physicians' services; but it could not pay only for drugs, for example, or only for physicians' services, or only for skilled nursing-home care. It is hoped, of course, that the States will develop programs paying for comprehensive services.

The Federal share in MAA will range from 50 percent to 80 percent of the costs of medical aid to the aged, depending on the per capita income of a State. There is no ceiling on the authorization. The first year of operation beginning with October 1, 1960, is expected to cost about $116 million ($60 million in Federal funds and $56 million in State-local funds).

Administrative provisions are identical with those covering old-age assistance. The MAA program, therefore, will be administered by State welfare agencies. The requirement for approval of a State plan--that there be either an established or designated State authority responsible for setting up and maintaining standards for public and private institutions rendering care under the program--may affect many State health departments now responsible for the licensure of hospitals and nursing homes.

The Public Health Service is keenly interested in problems of setting standards, and hopes for a similar interest within health departments. There is great need throughout the country for upgrading the quality of all types of services, including home health care and diagnostic, screening, and preventive services provided by both voluntary and official agencies.

CHILDREN'S BUREAU SERVICES IN 1960

Katherine Brownell Oettinger
Chief, Children's Bureau
Social Security Administration

In the year since I last addressed this group we have seen some significant milestones in the life of the Children's Bureau. As part of the Social Security Administration of the Department of Health, Education, and Welfare, we have shared in the celebration of the twenty-fifth anniversary of the Social Security Act. In a role traditional with us since the Bureau was founded, we participated in preparations for the Golden Anniversary White House Conference on Children and Youth and in the Conference itself. We are now well into our follow-up activities. Simultaneously we have moved forward in many of our on-going programs. Now we are looking ahead to our own fiftieth anniversary in April, 1962. All these events are symbols of the tremendous progress that has been made in health and welfare fields in the past fifty years.

To give you perspective on Children's Bureau health programs as they are today, I want to refresh your memories for just a moment on the climate of health activities that existed when the Social Security Act came into being. Writing on the "Origins and Development of the Health Services" under the Children's Titles in the Act, (Children, Vol. 7, No. 4) Dr. Martha Eliot said that the philosophy and principles of administration that influenced the initiation of the maternal and child health and the crippled children's programs were not new, but that they were to be applied "with a breadth of concept of what constitutes good care in health and sickness that was new. The guiding principles," she said, "stemmed from a fundamental concept developed early in our history that government in a democracy has a responsibility toward all the Nation's children."

As the child population has increased and the costs of medical care have risen, the Federal Government has recognized that it must offer more help to the States in meeting the increased costs of their programs. This recognition has been reflected in an increase in the authorization for the maternal and child health, the crippled children's, and the child welfare services programs to $25 million each.

The appropriations for both the maternal and child health and crippled children's programs have been increased over the previous year. The maternal and child health appropriation is now $18,167,000, and the crippled children's appropriation is $20 million. Changes in the language of Title V of the Social Security Act constitute another forward step that will make possible direct grants to universities,

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medical schools, and schools of public health, as well as to State health departments and crippled children's agencies.

There are obvious implications for your work in the Congressional action which, in raising the authorization for child welfare services to $25 million, emphasizes the needs of the mentally retarded. The Senate report on the amendments to Title V carried these words:

> "The need is now apparent for follow-up or other child welfare services to meet the special needs of these mentally retarded children. The increase of Federal funds ... would assure services to more counties by providing for more child welfare workers and equipping these workers through special training to provide better services for these mentally retarded children."

This supportive attitude of the Congress has been a matter of deep satisfaction to the Children's Bureau, for it moves some of our program goals closer to the range of possibility.

More and more the Children's Bureau is moving beyond a national concern for the health and welfare of children to an international interest. Public Law 610, passed by Congress this year, authorizes grants and other cooperative measures through which the Children's Bureau will be able to promote and support medical and health research throughout the world. We are now preparing budget statements relating to this law, outlining ways in which the Children's Bureau hopes to extend its research programs on an international basis.

At the present time Dr. Katherine Bain, Deputy Chief of the Children's Bureau, is in Russia as one of a team of six American scientists who are studying progress in the field of maternal and child health in the Soviet Union. The mission is being sponsored by the National Institute of Neurological Diseases and Blindness as a part of the scientific-cultural exchange program between the United States and the Soviet Union. When she completes her 30-day Russian assignment, Dr. Bain will visit maternal and child health facilities in both Poland and Yugoslavia to get firsthand impressions of ways we may work together to implement the new laws as they relate to needs in these countries.

During the past year there has been notable expansion in some aspects of the Children's Bureau grant programs. Both the maternal and child health and crippled children's programs have increased their activities in relation to speech and hearing defects. Last year nearly 3-1/2 million children received auditory screening tests in the schools. A technical conference on problems and methods of auditory screening and casefinding was held this spring under the joint auspices of the Children's Bureau, the American Speech and Hearing Association, and the Maryland Department of Health. The crippled children's program has increased the number of children to whom it has offered auditory and speech training and, when indicated, hearing aids.

Since audiology is a comparatively new science, the need for trained specialists is very great, and we are attempting to meet this need in part through special project grants for training. We are also working with the Office of Education, Office of Vocational Rehabilitation, Veterans Administration, and appropriate professional organizations to consider training needs and to develop ways of meeting them.

During 1960 and 1961 the Bureau, through its speech and hearing consultant, will be giving particular attention to providing technical assistance to State health departments in developing and expanding hearing conservation programs. At present only about half of the States have speech and hearing programs.

Congenital heart disease continues to be a major focus in Children's Bureau programs. Its expansion is characteristic of the way all our programs under crippled children's services need to expand to meet the rising demands placed upon them by population increases, earlier diagnoses, more extensive medical knowledge, and more advanced surgical procedures. Fifteen years ago nothing could be done for children with congenital heart disease. Now it is reported that surgery can result in cure or improvement for 80 percent of these children. The number of children with this one problem cared for under the crippled children's program has risen in less than a decade from 2,200 in 1950 to almost 14,500 last year, an increase of almost 560 percent.

More and more we are finding that we cannot limit ourselves to preconceived notions about our programs. As our technical knowledge increases, we are finding that we must cover a much broader range of conditions than formerly. Dental care of the retarded—a rather new field as a specialization— is a case in point. If you have not yet seen the study of dental problems of non-institutionalized, mentally retarded children which was done recently in Minnesota, I urge you to read it. This study, which grew out of a Children's Bureau supported four-county project for retarded children, showed some startling facts.

The prevalence of caries was lower among retarded children than among the normal control group--but the retarded children had lost many more teeth.

Sixty-six percent of the retarded children studied had moderate or severe periodontal disease. This fact appeared to be related to the poor oral hygiene and faulty brushing habits of the children. Sixteen percent of the retarded children had never used a toothbrush.

Between 75 and 80 percent of the permanent teeth of the retarded children needed care, but among the normal children only 11 percent needed care.

The findings of this study substantiated the Children's Bureau's feeling that special provisions for dental care of retarded children are apt to be needed in most areas. The work being done at the dental clinic for retarded and cerebral palsied children in Rhode Island seems

to the Bureau to be of such significance that we have encouraged the making of a film to illustrate this type of work for the information of other communities. The film is one of several on mental retardation recently supported by Children's Bureau funds. Another, on the public health nurse and the mentally retarded child, done in Oklahoma, was selected as one of the ten best films of the year by the University Film Council.

Recent Children's Bureau publications on mental retardation constitute another important part of its educational effort, and we are greatly pleased with the high demand for some of them. "The Child Who Is Mentally Retarded," brought out only four years ago, has reached a total distribution of almost a quarter of a million copies. "The Mentally Retarded Child at Home," which has been out less than a year, has sold more than 45,000 copies. Our latest publication in this area is "The Mongoloid Baby," a pamphlet for parents.

No report on retardation would be complete without a few words about phenylketonuria. The Children's Bureau has reviewed with its Technical Advisory Committee on Clinic Programs for Mentally Retarded Children what is presently known about prevention of retardation in children with this disorder. The report of the committee has been widely circulated to encourage more concentrated efforts at casefinding and early diagnosis. Many of your States, of course, took part in the Children's Bureau regional meetings held last year at which we made new findings about the diagnosis and treatment of PKU available to the State agencies. The increase in the number of detection programs, including those which have centered on the testing of siblings and cousins of children with PKU, is an encouraging example of the findings of research being put to work on the preventive level. Almost half of the States now have such programs. Dr. Willard Centerwall of Los Angeles has written a manual on the diagnosis of phenylketonuria, which will soon be published by the Children's Bureau.

We are deeply gratified that the crippled children's program of the Children's Bureau has been selected to receive a 1960 Albert Lasker award for its work in a program of medical care which has vitally helped 4-1/2 million children in the past 23 years. Dr. Arthur Lesser, director of our Division of Health Services, will accept the award at the American Public Health Association meeting in November.

> "This program is unique," the citation states, "in that it has stimulated the extension of the highest quality of services, developed new comprehensive ones when and where needed.... Despite its meager funds, the crippled children's program has made wide use of the potential strength in each community and has added thereto the scientific direction and specialized knowledge necessary to develop better services.... The future health of the nation's young and old would be greatly enhanced were other tax-supported medical care programs to strive for quality in the same spirit."

I know you will share my feeling that this recognition encourages all of us to maintain and advance the qualitative level of all our services. I want to add a special note of thanks to all of you who have played such a large part in making the crippled children's program an effective one.

Work is progressing or has been completed on several studies of interest to you. The three-State pilot study of the incidence of diagnosed cases of cystic fibrosis, which I mentioned to you last year, has been completed and the data is being processed. On the basis of this material, a decision is anticipated soon on whether to extend the study to the national level.

In response to a Congressional request for a report, the health and welfare resources of the Children's Bureau are being pooled in a joint effort to examine the special needs of children of migrant workers.

The need for protective services for children who suffer physical abuse at the hands of their parents has long been a matter of concern. Recently we have been conferring with a physician in Colorado who is studying the extent of abuses of this type. We expect to call a conference later in the year at which physicians, social workers, and members of related professions will be asked to help the Children's Bureau define its role in establishing necessary safeguards.

The joint Children's Bureau--National Institute of Mental Health report on juvenile delinquency, undertaken at the request of the Congress, resulted in the Children's Bureau series of 16 publications on such aspects as the size of the total problem, the usefulness of present means of identifying potential delinquents, qualifications of probation and police officers who work with juveniles, the need for family courts, and what is known about the social causes of delinquency.

The responsibility of the physician to study and understand early symptoms of individual and family behavior that might lead to delinquency is being recognized increasingly. The well-child clinics of your State programs and the few special clinics for adolescents that have been established provide one setting in which the physical factors that might contribute to anti-social behavior can be identified. Here, also, family problems may be identified and referred to appropriate agencies while they are still of manageable size. I hope you have seen the recent excellent report of the American Academy of Pediatrics on "The Pediatrician's Role in Preventing Delinquency," which grew out of the Arden House Conference on this subject. This is the most concrete and productive effort yet made to look squarely at the unique role of the physician in relation to this pressing problem of our society.

Our recent analysis of infant mortality figures for 1958 has shown us clearly how necessary it is to be vigilant in holding the medical gains we make. After a steady decline of many years, infant mortality rose in 1957 and again in 1958. Provisional rates for 1959 and the first six months of 1960 suggest that the rate is still somewhat elevated.

The most recent issue of the United Nations Demographic Yearbook (for 1959) gives us additional cause for concern. Figures in this report indicate that since 1950 the United States rate has dropped from sixth lowest to tenth place among reliably reporting countries. Sweden reports the lowest rate (15.8 deaths under one year per 1,000 live births) as contrasted with the United States' rate of 27.1 deaths. I'm sure all of us feel that we must double our efforts to assure that infant mortality in the United States is brought to and held at the lowest possible point.

Several major conferences of interest to you deserve a word here. The twentieth anniversary conference of the National Committee on Homemaker Service considered the question of what on-going mechanism should be established to keep abreast of all new program developments and to stimulate, advise, and help communities in their efforts to establish or improve homemaker services. No final agreement was reached during the conference on whether a new national organization should be set up, as had been proposed. It is anticipated that this and alternative plans will be considered again at an early date.

The medical profession as a whole seems to be aware of its growing responsibility in relation to homemaker services, and of how many calls for such services spring from illness in the home. The American Medical Association through its newsletter has spoken forcefully about the value of homemaker services. I am sure many of you know about the conference sponsored by the National Health Council on the limits of personal care that may be given by a homemaker, and I hope you have seen the report. It is a valuable contribution to one aspect of the effort to establish--while the patterns of homemaker service are still fluid--high standards that will assure an orderly and desirable kind of growth.

In November a national conference on day care, jointly sponsored by the Children's Bureau and the Women's Bureau of the Department of Labor, will bring together several hundred leaders representing both public and voluntary agencies. Not only agencies concerned directly with the operation of day-care centers but also those concerned with related areas of family life will be included: health, welfare, church, and educational groups; labor and industry; government agencies with programs related to children, and many others. I'm sure that all of you see instances in your own work where more adequate day-care facilities and programs are needed to supplement public health programs. I know you hope as I do that some valuable guidelines for the future development of day-care services will come out of this conference.

A number of conferences have been held on ways of implementing the recommendations of the White House Conference on Children and Youth. Reports from many States and communities indicate that they are well into their follow-up activities. At a recent meeting the Children's Bureau asked representatives of the National Council of State Committees to give us their suggestions about ways in which the Children's Bureau, the State committees, and the Council of National Organizations can best support the newly formed National Committee on Children and Youth.

As part of its follow-up responsibility, the Children's Bureau will offer consultant services to the States on ways of implementing White House Conference recommendations. We know that in this follow-up period we can continue to expect from you, as State and Territorial health officers, the same wholehearted participation we had during the preparation for the conference.

In the Children's Bureau proposal for celebration of our fiftieth anniversary in 1962, we have said, "Like the children whom it serves, the Bureau is more concerned with the future than with the past." We will try to define anew our specific responsibilities in relation to the total needs of children and young people. We shall look to you then, as we do now, for your continuing support as we move toward the goals we all share.

RECOMMENDATIONS
OF THE
STATE AND TERRITORIAL
HEALTH OFFICERS

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ENVIRONMENTAL SANITATION COMMITTEE

Chairman:	Russell E. Teague, M.D.	Kentucky
Vice Chairman:	Willis Van Heuvelen, M.S.	North Dakota
Members:	Kirk T. Mosley, M.D.	Oklahoma
	J. T. Herron, M.D.	Arkansas
	George W. Soffe, M.D.	Utah
	Jeremiah A. Dailey, M.D.	Rhode Island
	Richard H. Wilcox, M.D.	Oregon

The State and Territorial Health Officers recommend:

1. Extension of Water Pollution Control Act

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation extending without a time limit Section 5, Public Law 660, regarding financial aid to the States through program grants for water pollution activities; that the appropriation be increased from $3 million to $5 million per year; and that the secretary of the Association inform the Surgeon General of the Public Health Service, the Secretary of the Department of Health, Education, and Welfare, and the Congress of this recommendation.

2. Increasing Effectiveness of Construction Grants for Sewage Treatment Works

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation amending Public Law 660 with the view of increasing the effectiveness of the construction grants for the sewage treatment works program through:

a. Increasing the total appropriation authorization and the appropriation so authorized from $50 million to $100 million,

b. Increasing maximum grant provisions from $250,000 to $500,000,

c. Authorizing municipalities as individual applicants to band together in constructing joint projects,

d. Permitting reallocation among the States of funds unobligated six months after the beginning of the second fiscal year for which the funds were appropriated;

and that the secretary of the Association inform the Surgeon General of the Public Health Service, the Secretary of the Department of Health, Education, and Welfare, and the Congress of this recommendation.

3. Air Pollution Control

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation amending the Air Pollution Control Act (Public Law 84-159, as amended by Public Law 86-365) to authorize the Department of Health, Education, and Welfare to make program grants-in-aid on a project basis to State and local air pollution control agencies and that the secretary of the Association inform the Surgeon General of the Public Health Service, the Secretary of the Department of Health, Education, and Welfare, and the Congress of this recommendation.

4. Air Pollution Control Guidance Standards

That, in view of the growing significance of air pollution, State health departments give greater attention to the development and adoption of (a) guidance standards for ambient (community-wide) air quality to prevent health and other types of damage, and (b) guidance standards for emissions from pollution sources, taking into consideration desirable ambient air quality and the topographic, meteorologic, and other physical circumstances of areas to which such emission standards are applicable; and that the Public Health Service provide assistance to the States to this end, specifically by (a) intensifying its efforts leading to the development of the criteria and scientific facts needed to the promulgation of such air pollution standards, and (b) developing recommended guidelines appropriate for State or local use when supported by available evidence.

5. Elimination of Lead Hazard from Dishware

That the U. S. Public Health Service be requested to investigate methods by which the public may be protected from lead and other toxic hazards and by which the safety of dinnerware or other glazed products, used for food service and manufactured or sold in the United States, can be assured.

6. Solid Waste Disposal

That the Public Health Service substantially expand its research, consultation, and demonstration programs on storage, collection, and disposal of community solid wastes in the United States.

7. Certification of Foreign Sources of Shellfish

That the Public Health Service investigate the feasibility of establishing a program to ensure the sanitary quality of shellfish imported to the United States from foreign countries; and that such certification and rating program be consistent with the current Public Health Service programs for these products in the United States.

8. Research on Residual Pollutants

That the Public Health Service conduct water quality control research in the field of residual pollutants including the dissolved organic and inorganic materials, increased mineralization, and non-living contaminants; and establish new parameters for evaluating the potential hazards of such materials designed to fit the need for means of controlling the pollution of water from such materials.

9. Augmentation of Stream Flow

That Federal impoundments include storage capacity, on a non-reimbursable basis, for the augmentation of stream flow to maintain water quality, and that a copy of this recommendation be forwarded to appropriate Federal agencies and Congressional committees.

10. Housing

That the U. S. Public Health Service expand its activities to include essential research, technical assistance, and training in the public health aspects of housing, consistent with the current and expanding problems.

Association actions:

11. National Milk Sanitation Act

That each State health department endeavor to increase public support for the National Milk Sanitation Act by taking positive action to inform the public as to the advantages that will accrue to the milk consumer through the passage of this Federal legislation.

12. Medical Services in Traffic Safety

That the action of the National Safety Council in creating an additional inventory section dealing with medical services in traffic safety be endorsed.

13. Shellfish Sanitation

That each of the States be urged to protect its consuming public so that shellfish sold within its jurisdiction are of a safe sanitary quality and free from adulteration by requiring that all such shellfish be identified as having been handled by a plant or producer, certified by the State of origin, and whose name or names and identification numbers appear on the periodic Public Health Service list.

14. Food, Drug, and Cosmetic Control as an Integral Part of Public Health Practice

That the authority for food, drug, and cosmetic control be vested in State health agencies, and that the secretary of the Association inform

the Council of State Governments and the Secretary of the Department of Health, Education, and Welfare of this recommendation.

15. Ground Water Pollution

That each State not having such laws or regulations be urged to adopt effective laws to prohibit the discharge of raw or inadequately treated sewage or industrial wastes, or other drainage or waste water, into an excavation or well extending to or into any usable ground water aquifer; and to develop a program of inspection and control of all waste discharge, to protect ground water aquifers from direct or indirect pollution.

16. Name of Committee

That the name of this committee be changed to the Committee on Environmental Health.

FEDERAL RELATIONS COMMITTEE

Chairman:	Albert E. Heustis, M.D.	Michigan
Vice Chairman:	G. J. Van Heuvelen, M.D.	South Dakota
Members:	G. S. T. Peeples, M.D.	South Carolina
	R. N. Barr, M.D.	Minnesota
	E. A. Rogers, M.D.	Nebraska
	Carl N. Neupert, M.D.	Wisconsin
	John H. Venable, M.D.	Georgia

The State and Territorial Health Officers recommend:

1. Modification of Tuberculosis Control Grant Allocation Formula

That, before any changes are considered in the formula allocating categorical tuberculosis funds to the States, the Surgeon General, in cooperation with the Association, carefully study and consider the newly emerging problems of tuberculosis surveillance and control, including the increased need for the provision of post-sanatorium care and that a report be made to the Conference in 1961.

2. Cancer Control Grant Payments

That Public Health Service regulations Part 51.8 (d) (3) be changed to delete the present limitation on the amount of cancer control grant payments that may be made in the third and fourth quarter of any fiscal year.

3. Policies Governing Direct Grants to Institutions of Higher Learning

That the Surgeon General of the Public Health Service and the Chief of the Children's Bureau review with the Association the policies of these agencies governing direct grants to institutions of higher learning.

Association actions:

4. The Administration of Medical Care Funds for the Indigent

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation permitting the administration of medical care funds for the indigent to be placed with State health departments.

5. Fragmentation of Community Health Programs

That the Council of State Governments, in cooperation with the Association of State and Territorial Health Officers, in the interest of economy and efficiency be requested to study the problems of

fragmentation of health programs when various aspects of a total State health program are considered for placement in other than health agencies of State government.

6. Metropolitan Health Planning

That State health departments initiate and participate in metropolitan health planning to facilitate cooperation among health, planning, public works, and public welfare agencies in meeting the present and future needs of expanding communities; and that the Public Health Service be requested to conduct training, research, and field studies in this area.

7. Conferences with the Commissioner of the Food and Drug Administration

That the Executive Committee of the Association periodically invite the Commissioner of Social Security, the Commissioner of Food and Drugs, and the Director of the Office of Vocational Rehabilitation to meet with the Association on current problems of mutual concern.

HOSPITAL AND MENTAL HEALTH COMMITTEE

Chairman:	Mack I. Shanholtz, M.D.	Virginia
Vice Chairman:	D. G. Gill, M.D.	Alabama
Members:	Robert B. Aiken, M.D.	Vermont
	Charles L. Wilbar, Jr., M.D.	Pennsylvania
	Ralph E. Dwork, M.D.	Ohio

Association action:

1. Hill-Burton Appropriations

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation to appropriate the full authorized amounts under Parts C and G of the Hill-Burton Act, as amended; and that the secretary of the Association inform the Surgeon General of the Public Health Service, the Secretary of the Department of Health, Education, and Welfare, and the Congress of this recommendation.

INFECTIOUS DISEASES COMMITTEE

Chairman:	R. H. Hutcheson, M.D.	Tennessee
Vice Chairman:	A. L. Gray, M.D.	Mississippi
Members:	James W. Sampson, M.D.	Wyoming
	Edmund G. Zimmerer, M.D.	Iowa
	J. E. Peavy, M.D.	Texas
	C. G. Salsbury, M.D.	Arizona
	Stanley J. Leland, M.D.	New Mexico

The State and Territorial Health Officers recommend:

1. Tuberculosis in Foreign Students

That the Public Health Service initiate a better screening program for tuberculosis and other chronic communicable diseases among applicants for student visas before these students leave for this country; and that State health departments recommend to institutions in their jurisdiction close surveillance of these students, including periodic chest x-rays, especially during their early residence.

2. Uniform Stamp for Certifications of Immunization

That the respective State and Territorial health departments adopt a uniform stamp for authenticating International Certificates of Immunization which shall be a four-line stamp: Line one to read, "Official Vaccination"; line two to be the name of the State where used; line three to be the current IBM identification based upon the numerical code for States, counties, and cities of the United States; and line four to read, "U.S."

3. Smallpox Vaccinations for Personnel at U. S. Ports of Entry and Adjacent Community Areas

That the State and local health departments support the smallpox vaccination campaign to immunize persons servicing U. S. ports of entry by providing personnel and supplies to offer the vaccination when needed; also, that this campaign be furthered by smallpox vaccination, at appropriate intervals, of selected population segments at the community level.

Association actions:

4. Use of Experimental Biologicals in Open Communities

That the use of experimental biologicals affecting communities is a public health problem, and the official State health agency having

jurisdiction in the area of the anticipated experiment should be apprised of such anticipated experiment prior to its inception.

5. Follow-up on the Arden House Conference on Tuberculosis

That State health departments in cooperation with State tuberculosis and health associations should carefully consider recommendations for eradication of tuberculosis as made at the recent Arden House Conference, implementing those recommendations which are applicable in their States.

LONG-TERM ILLNESS AND HEALTH OF THE AGING COMMITTEE

Chairman:	Bernard Bucove, M.D.	Washington
Vice Chairman:	Perry F. Prather, M.D.	Maryland
Members:	G. D. C. Thompson, M.D.	Montana
	Roscoe P. Kandle, M.D.	New Jersey
	H. M. Hardwicke, M.D.	Missouri
	Daniel Leo Finucane, M.D.	District of Columbia
	L. L. Fatherree, M.D.	Illinois

The State and Territorial Health Officers recommend:

1. Policies Restricting Services to Recipients of Public Assistance

That the policies and guidelines established for cancer screening in the community cancer demonstration projects of the Cancer Control Program of the Public Health Service be clarified in order to stress that they are demonstration projects directed at high prevalence groups; and that State and local agencies be urged to accept the responsibility for cervical cancer screening among those women to whom they give medical care.

2. Chronic Illness Insurance

That the Surgeon General develop experimental programs wherever feasible which include extended insurance coverage as a basis for providing general hospital care, chronic hospital care, nursing home care, or care of patients in their homes; and that the State and Territorial health officers give every support in their jurisdictions should such programs develop in their areas.

3. Medical Care Programming

That the Public Health Service provide leadership in the medical care area by creating a program unit which will have responsibility for collecting and disseminating information, developing training for professional personnel, participating in studies and demonstrations, and consulting with all groups interested in this field.

4. Research and Special Project Grants

That the president of the Association select a committee to confer with the Surgeon General to explore further the policies and procedures referred to in Conference recommendation 3 submitted by the Committee on Long-term Illness and Health of the Aging at the 1959 meeting.

Association action:

5. Home Care

That the several State and Territorial health departments encourage the development of comprehensive home care programs and other care of patients in the home.

MATERNAL AND CHILD HEALTH COMMITTEE

Chairman:	Floyd I. Hudson, M.D.	Delaware
Vice Chairman:	J. W. R. Norton, M.D.	North Carolina
Members:	Geoffrey M. Martin, M.D.	Kansas
	Joseph Kovacs, M.D.	Guam
	Daniel J. Hurley, M.D.	Nevada
	R. L. Cleere, M.D.	Colorado
	Guillermo Arbona, M.D.	Puerto Rico
	William J. Rein, M.D.	Louisiana

The State and Territorial Health Officers recommend:

1. Gamma Globulin Prophylaxis

That the Public Health Service make a study of the availability and use of gamma globulin in the United States and that it publish recommendations for priorities in such usage.

2. Health Education Materials for Crippled Children's Work

That the Children's Bureau review present health education materials used in crippled children's programs and produce improved and new health education materials dealing with:

a. Physical, emotional, social, and spiritual aspects of the rehabilitation of the handicapped child; and

b. Information about certain handicapping conditions which would be understandable to parents and patients.

Association actions:

3. White House Conference Recommendations

That State and Territorial health departments review the recommendations regarding the care of mothers and children contained in State White House Conference reports; and in cooperation with State Committees on Children and Youth consider what action should be taken.

4. Children's Bureau-National Office of Vital Statistics Study of Cystic Fibrosis

That the State and Territorial health officers cooperate with the Children's Bureau and the National Office of Vital Statistics in a national survey of the incidence and prevalence of cystic fibrosis.

RESEARCH COMMITTEE

Chairman:	Malcolm H. Merrill, M.D.	California
Vice Chairman:	Herman E. Hilleboe, M.D.	New York
Member:	Alfred L. Frechette, M.D.	Massachusetts

The State and Territorial Health Officers recommend:

1. Programs for Demonstration and Application of New Research Findings

That the Public Health Service and the Children's Bureau take such actions as may be necessary to strengthen programs for research in public health practice.

2. Studies of the Transfer of Drugs, Chemicals, and Biological Substances Across the Placental Barrier and of the Excretion of Such Substances In Breast Milk

That the Children's Bureau promote definitive and quantitative studies of:

a. The transfer of drugs, chemicals, and biological substances across the placental barrier and their effects on the unborn child; and

b. The excretion of such substances in breast milk, and their effect on the infant.

3. Need for Public Health Service and Children's Bureau Consultation Service to States in the Field of Public Health Research

That the Public Health Service and Children's Bureau continue to develop an expanded consultation service to State departments of health toward development of all aspects of public health research.

4. Need for Research in Role of the Health Department in Programs Involving Several Agencies of State Government

That the Public Health Service undertake, promote, and support studies to determine the role of the health department and to delineate patterns of sharing joint responsibilities with other agencies in public health programs such as medical assistance to the aging and water pollution.

5. Institutional Grants for Research

That the Public Health Service, in the implementation of the program of institutional grants to promote research and research training

authorized by the 86th Congress in P.L. 86-798, award such grants to health departments as soon as possible.

Association action:

6. Sample Study of Hospitalization Data on Decedents

That the several State and Territorial departments cooperate with the U. S. National Health Survey and the National Office of Vital Statistics in their conduct of a national study to query hospitals and, in certain cases, family informants named on a sample of death certificates, drawn from the 10-percent current mortality sample, for a 12-month period in order to obtain data on hospitalization of the decedents in the year prior to death, which data will be used to supplement the current national estimates of hospitalization for the living population being produced by the U. S. National Health Survey.

SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE

Chairman:	N. H. Dyer, M.D.	West Virginia
Vice Chairman:	Richard K. C. Lee, M.D.	Hawaii
Members:	Franklin M. Foote, M.D.	Connecticut
	Terrell O. Carver, M.D.	Idaho
	Dean H. Fisher, M.D.	Maine
	Edward W. Colby, M.D.	New Hampshire
	Melvin H. Evans, M.D.	Virgin Islands

The State and Territorial Health Officers recommend:

1. National Study on Health Department and Motor Vehicle Administrator Cooperation

That the United States Public Health Service sponsor and inaugurate, with the cooperation of the Association of State and Territorial Health Officers, the American Association of Motor Vehicle Administrators, and the American Medical Association, a national study to determine what is being done with regard to cooperation between the motor vehicle administrator and the State health officer in each State and Territory and to identify areas where further cooperative effort is needed.

Association actions:

2. Public Health Aspects of Traffic Accident Control

That each State and Territorial health officer establish and maintain close and active cooperation with the State motor vehicle administrator in his State on problems involving the human aspects of traffic accidents.

3. Grants-In-Aid for Dental Programs

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation for a categorical grant-in-aid to assist State and Territorial health departments in developing adequate dental public health programs, and that the secretary of the Association inform the Surgeon General of the Public Health Service, the American Dental Association, and the Secretary of the Department of Health, Education, and Welfare of this recommendation.

4. Radiation Data Collection

That the several State and Territorial health departments cooperate with the Public Health Service in the inauguration and promotion of a continuing program for the collection and analysis of data bearing on the population dose from all sources of ionizing radiation.

5. Federal Training Grants

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation to amend H.R. 6871 as passed at the 86th Congress, 2d Session, to:

a. Remove the present $2 million ceiling on the project grants;

b. Provide for eligibility under the program to include any non-profit training or educational institution;

c. Appropriate for the fiscal year 1962 at least those minimum amounts recommended by the 1958 National Conference on Public Health Training;

and that the secretary of the Association inform the Surgeon General of the Public Health Service, the Secretary of the Department of Health, Education, and Welfare, and the Congress of this recommendation.

SPECIAL COMMITTEE ON DISASTER AND MEDICAL SERVICES AND HEALTH MOBILIZATION

Chairman:	J. T. Herron, M.D.	Arkansas
Vice Chairman:	Willis Van Heuvelen, M.S.	North Dakota
Members:	Russell E. Teague, M.D.	Kentucky
	Kirk T. Mosley, M.D.	Oklahoma
	George W. Soffe, M.D.	Utah
	Jeremiah A. Dailey, M.D.	Rhode Island
	Richard H. Wilcox, M.D.	Oregon

The State and Territorial Health Officers recommend:

1. Appropriations for Civil Defense

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation to make adequate grant-in-aid appropriations to the States and Territories to implement Public Law 85-606, including funds specifically for health activities; and that the secretary of the Association inform the Congress and the director of the Office of Civil and Defense Mobilization of this recommendation.

2. Health Mobilization Training

That the Public Health Service, the Department of Health, Education, and Welfare, and the Office of Civil and Defense Mobilization seek funds for health mobilization training to:

a. Expand baseline courses conducted by the Public Health Service to include at least one such course per year for each specialized function;

b. Extend Federal support for undergraduate health mobilization training to the undergraduate curriculum for dental, nursing, engineering, veterinarian, and other health professional groups, along the lines of current training for physicians;

c. Incorporate health mobilization into each public health training program;

d. Establish one or more health mobilization training centers at selected medical institutions to provide broad training at the postgraduate level on all aspects of health mobilization;

e. Expand the training staff of the Public Health Service to provide training materials for State-conducted courses; and

f. Establish a program of training grant-in-aid to States to implement the training of auxiliary health personnel and the public.

Association actions:

3. Health Mobilization Problems

That several State and Territorial health officers aggressively assume their roles in the preparation for civil defense emergencies as outlined in the National Plan and its annexes, particularly annexes 18, 24, 30, and 32; and that a copy of this recommendation be sent to the Director of the Office of Civil and Defense Mobilization with a request that he send copies to his regional directors for redistribution to State directors of civil defense.

4. Calibration and Maintenance of Civil Defense Radiation Detection Instruments Distributed by the OCDM to the State and Local Civil Defense Agencies and Local School Systems

That State health departments, whenever possible, assume responsibility for maintenance of radiation detection instruments in State and local custody in serviceable condition and calibration at least once yearly; and further that the OCDM participate in the cost of provision of such services to at least 50 percent.

5. Federal Emergency Health Service

That the role of the Public Health Service in the development of the emergency health service be endorsed; that the State and Territorial health departments under delegated authority from OCDM assume a similar role at the State level, whenever possible; and that the Public Health Service retain a small cadre to provide continuity of the present Public Health Service organization.

6. Medical Emergency Radio Service

That the Association of State and Territorial Health Officers take action to establish a joint committee with other interested health associations and agencies to study and organize a plan for normal and emergency health radio communications; and that the Association act immediately to request that the Federal Communications Commission reserve suitable frequencies until this matter is resolved.

7. "Your Health in a Fallout Shelter"

That the Association of State and Territorial Health Officers endorse and urge the publication and distribution of the document tentatively entitled, "Your Health in a Fallout Shelter."

SPECIAL COMMITTEE ON INDIAN AFFAIRS

Chairman:	C. G. Salsbury, M.D.	Arizona
Members:	Stanley J. Leland, M.D.	New Mexico
	James W. Sampson, M.D.	Wyoming
	J. E. Peavy, M.D.	Texas
	R. H. Hutcheson, M.D.	Tennessee
	A. L. Gray, M.D.	Mississippi
	Edmund G. Zimmerer, M.D.	Iowa

The State and Territorial Health Officers recommend:

1. Mental Health Consultant

That the Public Health Service make a special effort to provide at least one mental health consultant to each area office of the Division of Indian Health.

2. Sanitation Program

That the United States Public Health Service continue with the present sanitation program giving due regard to the special needs of the community and maintaining liaison with the various States with respect to these projects.

SPECIAL COMMITTEE ON MIGRANT LABOR

Chairman:	R. L. Cleere, M.D.	Colorado
Vice Chairman:	Guillermo Arbona, M.D.	Puerto Rico
Members:	Floyd I. Hudson, M.D.	Delaware
	Geoffrey M. Martin, M.D.	Kansas
	Joseph Kovacs, M.D.	Guam
	Daniel J. Hurley, M.D.	Nevada
	William J. Rein, M.D.	Louisiana
	J. W. R. Norton, M.D.	North Carolina

The State and Territorial Health Officers recommend:

1. Study of Effects of Insanitary Field Conditions

That the Public Health Service cooperate with the Association of State and Territorial Health Officers in:

a. Research to assess the risk of transmission of diseases resulting from present insanitary working conditions among agricultural workers, or from agricultural workers to consumers of products which they harvest; and

b. The development of practical solutions to the problems of insanitary conditions in the working environment in order to protect the health of consumers as well as that of the workers, and to strengthen health education efforts among the latter.

2. Health Services for Migrant Workers and their Families

That the Public Health Service reappraise the priority assigned to the health problems -- including problems incident to the provision of medical care -- arising from the presence of domestic agricultural migrants in both home-base and work areas, and seek additional funds and authority to provide technical and financial assistance to the States, including project grants.

Association actions:

3. Telephone Listings of Health Agencies

That the Executive Committee of the Association explore possibilities and take such steps as may be feasible to obtain a uniform telephone listing for all public health agencies, State and local, under some heading such as "health," possibly with a reference to the appropriate place to find a particular agency's telephone number in the local telephone directory.

4. Adoption of Uniform Health Record for Agricultural Migrants

That the States adopt the health record for use with agricultural migrants which has been developed by the Public Health Service with the cooperation and advice of a number of State and local health departments.

RESOLUTIONS

PERTAINING TO PUBLIC HEALTH ACTIVITIES

ADOPTED BY THE

STATE AND TERRITORIAL HEALTH OFFICERS

Resolutions Committee

Chairman:	D. G. Gill, M.D.	Alabama
Vice Chairman:	Mack I. Shanholtz, M.D.	Virginia
	Charles L. Wilbar, Jr., M.D.	Pennsylvania

RESOLUTION No. 1

Medical Care of the Aged

Whereas the Association of State and Territorial Health Officers feels strongly that efforts to provide health services and medical care for the aged should emphasize:

1. optimum preventive and restorative services,

2. high quality care and quality controls with opportunity for review of all services,

3. clear standards for eligibility of recipients,

4. standards not only of services but also for facilities and personnel,

5. the need for a constellation of related social services, and

6. the recognition that successful efforts in providing care to the aged is a part of planning for hospitals and closely related medical facilities as well as the licensing and upgrading of such facilities; and

Whereas health departments have traditionally had basic responsibilities and skills in the area of health services and have successfully demonstrated their ability in the administration of health programs; and

Whereas health departments are active in the planning of hospital and related medical facilities; and

Whereas health departments have ready communication with the health professions: Therefore, be it

RESOLVED, That the Association of State and Territorial Health Officers initiate and support legislation to include:

1. that Federal law be amended to allow for State option regarding agency participation in Federally supported medical care programs and that these programs be developed to achieve maximum participation of public health agencies, Federal, State, and local, in their administration; and considering that

2. in the complicated field of providing comprehensive medical care to the aged involving many aspects of public assistance as well as the health care of individuals in all its phases, prevention, treatment, and rehabilitation, the principle of single agency responsibility may not be applicable;

3. that in order to achieve the goals outlined above, the program now designated as "Medical Assistance to the Aged" be separated from the categorical public assistance program and be administered primarily as a program of health service to the aged rather than as a welfare program; and be it further

RESOLVED, That in the face of existing legislation, health departments at all levels be urged to participate with relevant bodies in activities such as contracts, cooperative efforts, consultation procedures, advisory bodies, and other arrangements which will achieve maximum coordination of efforts in the development of health services to the aged.

RESOLUTION No. 2

National Conference on Traffic Safety

Whereas traffic accidents cause nearly 40,000 deaths and 1,000,000 persons to be injured severely enough to be hospitalized in this nation annually; and

Whereas traffic accidents are truly a major public health problem; and

Whereas health departments have been increasingly involved in accident prevention, but to only a relatively small degree in traffic accident prevention; and

Whereas the human factors concerned with traffic accidents constitute the most important of the causative factors; and

Whereas medical and other health personnel are capable and competent to study and make recommendations toward reduction of the human factors causing traffic accidents; and

Whereas motor vehicle administrators are turning to health officers and health departments more and more for help in this area; and

Whereas the American Medical Association has shown increasing interest in participation in this area: Therefore, be it

RESOLVED, That the Association of State and Territorial Health Officers recommend close working relationships between its members and their respective motor vehicle administrators; and be it further

RESOLVED, That it is the desire of the Association of State and Territorial Health Officers to maintain close working relationships with organized medicine in this field, at the national, State, and local levels; and be it further

RESOLVED, That the Association of State and Territorial Health Officers recommends that the State or Territorial health officer should be a member of the governor's traffic safety council and a member of interdepartmental committees on traffic safety, wherever such organizations exist; and be it further

RESOLVED, That the Association of State and Territorial Health Officers recommends that regional traffic safety workshops be arranged by the regional medical directors of the Public Health Service with State and Territorial health officers and their corresponding State motor vehicle administrators in attendance; and be it further

RESOLVED, That a national conference on traffic safety be called by the Secretary of Health, Education, and Welfare; and be it further

RESOLVED, That copies of this resolution be transmitted to the American Association of Motor Vehicle Administrators, the American Medical Association, and the Secretary of Health, Education, and Welfare.

RESOLUTION No. 3

Water Pollution

Whereas Section 5 of Public Law 660 expires in 1961; and

Whereas this section of the law has been of much benefit to the States in stimulating expanded and improved water pollution control programs, and because these program grants are needed for future expansion and improvement of administration of their programs: Therefore, be it

RESOLVED, That the Water Pollution Control Program Grants authorization, Section 5 of Public Law 660, be extended beyond the expiration date in 1961 and that the annual appropriation be increased to $5 million.

RESOLUTION No. 4

Nursing Education

Whereas the National League for Nursing has decided that it will no longer accredit programs in nursing which provide for specialization in public health (or any other subject) at the baccalaureate level; and

Whereas the League's policies relating to baccalaureate education require that courses be taken in a "proper" sequence, which relegates courses specifically dealing with public health to the second and/or third years of such training; and

Whereas the League does not accredit one-year (30 semester hours) programs beyond the three-year hospital school programs for certification of public health nurse training, as was done for some time by the National Organization for Public Health Nursing; and

Whereas there is a tendency for university schools of nursing and certain schools of public health to give only the courses accredited by the National League for Nursing; and

Whereas this is leading to a reduction of available facilities in the nation for presentation of one-year (30 semester hours) courses for training in public health nursing; and

Whereas there continues to be great need for these one-year courses since only 37.1 percent of staff public health nurses in the nation at present have had 30 or more credited hours of collegiate training for public health nursing and only a small number of this 37.1 percent have baccalaureate degrees; and

Whereas many nurses unprepared for public health nursing, but desirous of practicing public health nursing, are not interested in obtaining a baccalaureate degree; and

Whereas the need for public health nurses is increasing more rapidly than any reasonably contemplated program for graduating nurses with baccalaureate degrees could meet: Therefore, be it

RESOLVED, That the Association of State and Territorial Health Officers commend the National League for Nursing for bringing about needed improvement in courses which lead to baccalaureate degrees for nursing, including public health nursing; but be it further

RESOLVED, That the Association of State and Territorial Health Officers recommend to the National League for Nursing that the League accredit university schools of nursing and schools of public health for issuing certificates of public health nursing for 30-semester hour courses in public health nursing and thus encourage having a more adequate supply of such courses available for some years to come; and be it further

RESOLVED, That the Association of State and Territorial Health Officers recommend that the American Public Health Association approve 30-semester hour courses in public health nursing in schools of public health giving undergraduate courses in public health nursing; and be it further

RESOLVED, That the Association of State and Territorial Health Officers encourage universities and schools of public health to conduct 30-semester hour programs of training for public health nursing regardless.

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